BlueCross BlueShield of Illinois | *Experience. Wellness. Everywhere.®*

BlueREVIEW

FOR CONTRACTING INSTITUTIONAL AND PROFESSIONAL PROVIDERS

FEBRUARY 2010

WHAT'S INSIDE?

Clarification: Timely Filing Requirement Changes

We would like to clarify that the language included within the "Timely Filing Requirement Changes" article on page 11 of our January *Blue Review* will become the contractual obligation of **Professional PPO and Blue*Choice* Select providers**, effective April 1, 2010.

Due to the varied timely filing requirements of different employer groups, we would like to encourage **all providers** to file within 180 days to avoid claim denials. If you have any questions concerning this notice, please contact your Provider Network Consultant.

In the News: Coverage for Routine Cancer Screenings

There has been a great deal of dialogue regarding revised cervical cancer screening guidelines proposed by the American Congress of Obstetricians and Gynecologists (ACOG), and updated breast cancer screening guidelines as proposed by the U.S. Preventive Services Task Force (USPSTF) in November 2009.

Rather than annual Pap tests, the ACOG now recommends less frequent screening for certain age groups and for women where no other risk factors are present. Similarly, the USPSTF now recommends less frequent (biennial) mammography screening, with screenings limited to women aged 50 to 74 years.

BCBSIL CONTINUES COVERAGE

BCBSIL regularly monitors research to ensure that our medical policies are current. At this time, our policies and coverage related to cervical and breast cancer screenings remain unchanged. **BCBSIL will continue to provide benefit coverage for routine Pap tests and mammograms for women as ordered by their physicians to the extent benefits are available under the member certificate.**

MEMBER AWARENESS

This message has also been posted on our secure Blue Access for Members site at *www.bcbsil.com*. As always, we recommend that our members consult with you, their physician, if they have questions or concerns regarding the clinical appropriateness of a particular test.

If BCBSIL members have questions regarding coverage, they should call the customer service number on the back of their member ID card.

References:

1. "First Cervical Cancer Screening Delayed Until Age 21, Less Frequent Pap Tests Recommended," ACOG Press Release, Nov. 20, 2009 (*www.acog.org/from_home/publications/press_releases/nr11-20-09.cfm*).
2. USPSTF "Screening for Breast Cancer Recommendation Statement" and "Summary of Recommendation and Evidence," November 2009 (U.S. Department of Health and Human Services Web site: *www.ahrq.gov/clinic/uspstf09/breastcancer/brcanrs.htm*).

FAIRNESS IN CONTRACTING

In an effort to comply with Fairness in Contracting Legislation and keep our independently contracted providers informed, BCBSIL has designated a column in the *Blue Review* to notify you of any changes to the physician fee schedules. Be sure to review this area each month.

Effective Feb. 1, 2010, code J7330 was updated.

Effective March 1, 2010, the following code ranges will be updated: A9576 - A9581, J0120 - J9600, P9041 - P9048, Q0138 - Q9967, S0012 - S0191. Please note that not all codes in these ranges will be updated.

Effective May 1, 2010, immunizations, vaccines and toxoids in the 90287 - 90748 code range will be updated. Please note that not all codes in this range will be updated.

Annual and quarterly fee schedule updates can be requested by downloading the Fee Schedule Request Form at *www.bcbsil.com/provider/forms.htm*. Specific code changes that are listed above can also be obtained by downloading the Fee Schedule Request Form and specifically requesting the updates on the codes listed in the *Blue Review*.

SAVE THE DATE: SPRING MANAGED CARE ROUNDTABLE, MARCH 4

The Spring Managed Care Roundtable will be held on Thursday, March 4, 2010, from 8 a.m. to 11:30 a.m. in the

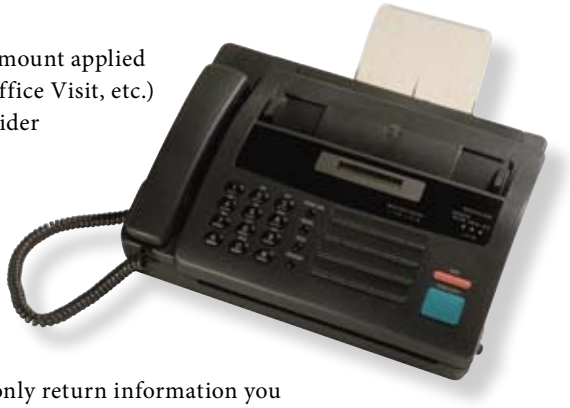
BCBSIL Auditorium
300 E. Randolph St.
Chicago, Illinois, 60601

Visit us online at *www.bcbsil.com/provider/training.htm* for registration details.

New! Fax Confirmation for Benefits & Eligibility Requests

You now have the option to receive a fax confirmation of eligibility and benefits information obtained through our Interactive Voice Response (IVR) phone system. This fax confirmation will contain the same details delivered to you by the IVR system, including but not limited to:

- Effective date
- Pre-existing date
- Health Care Account (HCA), and the amount applied
- Benefit Category requested (Surgery, Office Visit, etc.)
- Place of Treatment selected by the provider
- Copay and Deductible amounts
- Disclaimers (Example: HMO – "Services are based on PCP referral and group approval")
- Pre-certification* requirements (*also referred to as preauthorization or prenotification)



Please keep in mind that the system will only return information you have specifically requested.

HERE'S HOW IT WORKS. . .

After receiving a quote of eligibility and benefits, you will be given the option to request a fax confirmation. Upon responding "Yes," you will then be prompted to provide your fax number, including area code. The number can be spoken or entered by touch-tone, and should contain only 10 digits, not the preceding "1." You should receive your faxed confirmation the same day.

Tip: When researching multiple benefits for one or more patients, choose "Yes" after each eligibility and benefits quote if you anticipate needing a fax confirmation for any or all of your requests. This will help ensure that you do not need to "start over" by selecting "Check another patient" or "Main Menu" in order to get back to the eligibility portion of the IVR.

For Caller Guides with additional information on how to conduct specific transactions via the IVR, visit the Interactive Voice Response System page in our online Provider Library at *www.bcbsil.com/provider*.

Note: The fax confirmation option is available only through the automated IVR system. The fax confirmation is not available when eligibility and benefits are quoted by a Customer Advocate.

At BCBSIL, we recommend conducting transactions electronically where possible to help you save time and money and reduce paper in your office. Please visit the Electronic Commerce section of our Web site at *www.bcbsil.com/provider* for more information on Electronic Data Interchange (EDI) transactions.

If you do not have online access, our Provider Telecommunications Center (PTC) is available to assist you with requests for claims status, benefits and eligibility information for BCBSIL members. Just call us at (800) 972-8088 – our automated IVR phone system is available Monday through Friday, 6 a.m. to 11:30 p.m., CT, and Saturday, 6 a.m. to 3 p.m., CT.

Stay Informed with Electronic Commerce 'Alerts'

Does your office submit claims electronically or receive claim payments via Electronic Funds Transfer (EFT)? Are you enrolled for Electronic Remittance Advice (ERA)/ Electronic Payment Summary (EPS)? If you conduct business electronically with BCBSIL, it is very important to become a regular visitor to our online Electronic Commerce (E-Commerce) "Alerts" page at *www.bcbsil.com/provider/ec/alerts.htm*.

E-Commerce Alerts provide notification of system enhancements, upgrades, new functionality, and any Electronic Data Interchange (EDI) transaction issues that may affect claims processing, payment or remittance delivery. This includes system downtime alerts, as well as edit/automatic error code implementation notices and Warning ("W") / Rejection ("R") status changes.

The Alerts section also houses our 2010 corporate holiday schedule to help you project EFT delivery and system/report availability throughout the year. Although it is possible for providers to submit claims electronically, receive EFT and retrieve ERA/EPS at almost any time during the year, it is important to keep in mind that corporate and legal banking holidays may affect the normal processing, payment and report availability schedule.

If you have any questions regarding Alert notifications, contact our Electronic Commerce Center at (800) 746-4614 for assistance.

Paper-to-Electronic (PCS-to-EPS) Transition Reminders

When you enroll for the ERA, you are automatically enrolled for the EPS. Here are some important reminders regarding your transition to the EPS, which replaces your paper Provider Claim Summary (PCS) once you are enrolled for ERA/EPS:

If you are a new ERA/EPS enrollee,

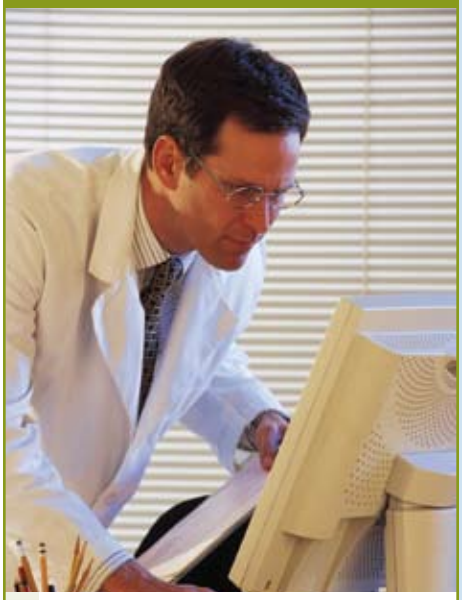
- You will continue to receive your paper PCS for 30 days after you start receiving your ERA and EPS files.
- This 30-day transition period is designed to help your office make a gradual switch from paper to electronic processing.
- When the transition period ends, the PCS will be discontinued and you will receive only the ERA/EPS going forward.

If you enrolled for ERA/EPS directly or through your clearinghouse/billing agent more than a month ago,

- You may have continued to receive both the ERA/EPS and the PCS in your office for longer than 30 days.
- Please be advised that your PCS will now be discontinued. Going forward, you will receive only the ERA/EPS.

If you are unsure whether or not your office is enrolled for ERA/EPS, or if you believe that you are no longer enrolled through your current billing agent/clearinghouse, please contact our Electronic Commerce Center at (800) 746-4614 for assistance on how to proceed.

IN THE KNOW ✓ | EPS Formatting Tips



The EPS is delivered by BCBSIL as a text file so that it can be received in conjunction with your ERA.* The EPS contains the same information as the paper Provider Claim Summary (PCS). You can save the EPS as an electronic file for future retrieval; or, you may choose to select and print some or all of the document.

Here are some **formatting tips** for proper viewing when downloading your EPS to help ensure that it looks like the PCS, as you may expect:

- ✔ Open the document in Microsoft Word, WordPad, etc.
- ✔ Set the page layout as landscape, rather than portrait
- ✔ For the font style, select Courier New
- ✔ For the font size, select 8 point

***Note:** If you are utilizing a billing agent, the EPS goes to the receiver/ vendor/clearinghouse. Delivery or posting specifications are determined by the vendor, not BCBSIL. Therefore, you should check with your receiver/ vendor/clearinghouse to determine whether or not special software may be needed to view the EPS file.

BlueCard® Tip:

Medical Record Process Improvements for Out-of-area Claims

Blue Cross and Blue Shield Plans nationwide are continuing to improve the process of receiving and sending medical records. Electronic transmission of medical records between Blues Plans reduces the need to request records multiple times and eliminates the problem of lost or misrouted records for out-of-area claims.

Reminders

- If you receive requests for medical records from other Blues Plans **prior to rendering services** or submitting your claim, please submit all requested information directly to **the requesting Plan**.
- If medical records are needed **during the claim process**, you will receive a letter from us specifying exactly what information you need to send to **BCBSIL**.
- ***Submit medical records only when you are requested to do so.*** Submitting unsolicited medical records can jeopardize your patient's protected health information (PHI) or sensitive personal information (SPI). If medical records are needed, BCBSIL will specify the ***minimum necessary*** information you need to send us so that we may process your claim.

For More Information

If you have any questions about filing claims for Blue Plan members, please refer to the BlueCard Program Manual on our Web site at *www.bcbsil.com/PDF/bluecard_program_manual.pdf*.

We Value Your Feedback

Share your out-of-area member servicing experiences with us via e-mail at *provider_relations@bcbsil.com*.

PHARMACY PROGRAM UPDATES

Generic Equivalent and Over-the-Counter Formulation Now Available for Prevacid®

The generic equivalent and an over-the-counter (OTC) formulation of oral Prevacid capsules, or lansoprazole, have been launched. Prevacid is a proton pump inhibitor (PPI) indicated for use in adults and pediatric patients for the treatment of ulcers and gastroesophageal reflux disease. The other highly utilized medication available generically in this class is omeprazole. The use of generic medications as first-line therapy is encouraged, whenever appropriate.

PROTON PUMP INHIBITOR STEP THERAPY CRITERIA CHANGES

The step therapy (ST) criteria for PPIs has been revised to include lansoprazole as a prerequisite, with the launch of prescription generic lansoprazole (both 15 mg and 30 mg strengths), The intent of PPI ST is to encourage the use of a cost-effective medication in this drug class before progressing to a more costly medication, if necessary.

The PPI ST criteria are as follows, depending on the ST implementation date:

- If PPI ST is implemented on or before Jan. 1, 2010, the edit will require therapy with a preferred generic PPI before coverage is available for any brand PPI or nonpreferred generic PPI.
- If PPI ST is implemented after Jan. 1, 2010, the edit will require therapy with a preferred PPI (generic or brand) before coverage is available for a nonpreferred PPI (generic or brand).

OTC EQUIVALENT EXCLUSION PROGRAM CHANGES

The OTC formulation of Prevacid is available in the 15 mg strength only and is being marketed as Prevacid 24HR. Coverage for groups whose benefit includes the OTC Equivalent Exclusion Program is as follows:

- ***Groups that currently provide coverage for prescription generic omeprazole:*** Coverage for prescription generic lansoprazole has automatically been added. Under this program, members with a valid prescription will receive coverage for prescription generic omeprazole or lansoprazole.
- ***Groups that currently do not cover prescription generic omeprazole:*** Prescription brand Prevacid and generic lansoprazole will automatically be excluded from coverage.

The OTC version, Prevacid 24HR, is not covered under the prescription drug benefit.

**Source: http://www.cdc.gov/NCCdphp/overview.htm*

Authorized Generics of Adderall XR® Excluded from Coverage

In April 2009, an authorized generic of the non-formulary brand drug Adderall XR was launched. Authorized generics are versions of a prescription drug produced or licensed by its original developer under the New Drug Application (NDA) of the original brand drug. Unlike true generics, authorized generics are not approved for marketing under an Abbreviated New Drug Application (ANDA), which is an application that must be submitted to the FDA for a *generic drug* approval. Therefore, due to the nature of the FDA filing, authorized generics are equivalent drugs of the brand product (that might be marketed under a different brand name or the chemical name) but instead of being considered as generics, they are considered to be brand products. Also, authorized generics generally do not cost less than the brand medication.

Effective Jan. 1, 2010, the authorized generic products of Adderall XR, amphetamine-dextroamphetamine SR capsules, have been excluded from coverage under the pharmacy benefit. Adderall XR will remain covered as a non-formulary product. This should help avoid confusion for members who believe the authorized generic should be adjudicating at the generic copayment level. At the point of sale, the amphetamine-dextroamphetamine SR capsules will be rejected and the pharmacist will be alerted with the message "NDC not covered, use Adderall XR." Communication has also been provided to pharmacies on this topic.

Medicare Part D Pharmacy Updates

Every month, we post a new Medicare Part D-related article in the Pharmacy section of our Web site at *www.bcbsil.com/provider*. These articles are intended to help keep you up-to-date on Medicare Part D formulary changes, U.S. Food and Drug Administration (FDA) safety updates, Part D Gap strategies, overlapping coverage between Part B and Part D drugs, and more.

Here is a brief summary of this month's article, which features the following topic:

Extended-release Niacin vs. Ezetimibe

Results of the ARBITER 6-HALTS Trial

On Nov. 15, 2009, the *New England Journal of Medicine* released the results of the ARBITER 6-HALTS trial to coincide with presentations at the American Heart Association Scientific Sessions. In this comparative-effectiveness trial, the authors conclude that combining chronic statin monotherapy with a treatment [i.e., extended-release niacin (NIASPAN)] intended to raise high-density lipoprotein cholesterol (HDL-C) is more effective at reducing carotid intima-media thickness (IMT) than an adjunctive therapy [ezetimibe (ZETIA)] utilized to further lower low-density lipoprotein cholesterol (LDL-C).

Visit the Medicare Part D Updates archives in the Pharmacy section of our Provider Web site at *www.bcbsil.com/provider* for the complete article, which includes details on methods used, study results, clinical discussion, conclusion and a complete reference list.

Pharmacy Disclaimer

The information provided above is for informational purposes only and is not a substitute for the independent medical judgement of a physician. Physicians are instructed to exercise their own medical judgement.

Member ID Cards Have a New Look!

All Blue Cross and Blue Shield plans will be adopting a standardized format on ID cards. Although the information contained on the ID card is mostly the same, the placement may be different.

BCBSIL is phasing in the distribution of these new cards, so some of your patients will have the new member ID card, while others may still present the old ID card. Both versions are valid until Jan. 1, 2011, at which time all members will have new cards.

An important new feature is the addition of a magnetic stripe to the back of the ID card, containing member information that can be read when "swiped" by a card reader. This information includes the subscriber's name, birth date, ID number and group number for generation of electronic eligibility and benefits inquiry and response (ANSI 270/271) transactions.

To protect our members' privacy, information on the ID card can only be read by track-three card readers. *Note: The new member ID card is not a credit or debit card, and there is no financial or medical information stored on the magnetic stripe.*

If your office already has a track-three card reader and connectivity with an approved third-party vendor, you should be able to access the data on the magnetic stripe. If you have any questions or need additional information, please contact your Provider Network Consultant.

Provider Manual Update

The following language will be added to the BCBSIL Provider Manual, effective May 1, 2010. **This applies to all contracted Professional PPO and Blue*Choice* providers as of the effective date mentioned above**. If you have any questions about this update, please contact your assigned Professional Provider Network Consultant for assistance.

DISPUTES

I. Any disputes arising out of the terms of the Provider Agreement shall be governed by and subject to the laws of the State of Illinois.

II. In order to avoid the cost and time consuming nature of litigation, any dispute between Plan and Contracting Provider arising out of, relating to, involving the interpretation of, or in any other way pertaining to this Agreement or any prior Agreement between Plan and Contracting Provider shall be resolved using alternative dispute resolution mechanisms instead of litigation. Plan and Contracting Provider agree and acknowledge that it is their mutual intention that this provision be construed broadly so as to provide for individual mediation and/or arbitration of all disputes arising out of their relationship as third-party payer and provider. The parties further agree that resolution of any dispute pursuant to the Provider Agreement shall be in accordance with the procedures detailed below.

A. Initial Resolution by Meeting or Mediation of Dispute

1. Plan or Contracting Provider, as the case may be, shall give written notice to the other of the existence of a dispute (the "Initial Notice").

2. If Plan and Contracting Provider mutually agree that a meeting to attempt to resolve the dispute would be advantageous, representatives of Plan and Contracting Provider shall meet not later than thirty (30) calendar days after delivery of the Initial Notice in order to attempt to resolve the dispute. Subsequent meetings may be held, if mutually agreed.

3. If no meeting is mutually agreed, or if the dispute is not resolved at any meetings held, the party giving the Initial Notice shall submit the dispute to mediation by an organization or company specializing in providing neutral, third-party mediators. The mediation process shall be coordinated by the submitting party with the mediator and shall be subject to the following agreed-upon conditions:

   a. The parties agree to participate in the mediation in good faith;

   b. The parties agree to have present at the mediation one or more individuals with decision-making authority regarding the matters in dispute. Either party may, at its option, be represented by counsel. Contracting Provider may, at its option, also have present at the mediation a representative of any professional society of which it is a member;

   c. The mediation will be held in Chicago, Illinois, within sixty (60) days of the submission to mediation, unless the parties mutually agree on a later date or a different venue;

   d. The parties shall each bear their own costs and shall each pay one-half of the mediator's fees and costs, unless the mediator determines that one party did not participate in the mediation in good faith, in which case that party shall pay all of the mediator's fees and costs;

e. The parties agree that the obligation to mediate (but not the obligation to arbitrate) is not applicable to any dispute that was pending in any court on the effective date of the Provider Agreement, or that had been submitted to binding arbitration on or before the effective date of the Provider Agreement.

B. Binding Arbitration

In the event mediation is not successful in resolving the dispute, either Plan or Contracting Provider, on Contracting Provider's own behalf and not as a representative of a purported class, may submit the dispute to final and binding arbitration under the Rules of Procedure of Arbitration of the American Health Lawyers Association, subject to the following:

1. The arbitration shall be conducted by a single arbitrator selected by the parties from a list furnished by the American Health Lawyers Association. If the parties are unable to agree on an arbitrator from the list, the arbitrator shall be appointed by the American Health Lawyers Association.

2. The arbitrator shall be required to render a written decision resolving all disputes, and designating one party as the "prevailing party."

3. Except in the case of fraud, no arbitration decision may require any adjustment in reimbursements or payments respecting any dispute involving services rendered more than eighteen (18) months prior to receipt of the Initial Notice.

4. The costs of arbitration, including the arbitrator's fee and any reporting or other costs, but excluding lawyers', consultants' and witness fees, shall be borne by the non-prevailing party unless the arbitrator determines as part of his or her award that such allocation is inequitable under the totality of the circumstances.

5. Contracting Provider acknowledges that this provision agreement precludes Contracting Provider from filing an action at law or in equity and from having any dispute covered by this Agreement resolved by a judge or jury. Contracting Provider further acknowledges that this arbitration provision precludes Contracting Provider from participating in a class action or class arbitration filed by any other provider or any other plaintiff claiming to represent Contracting Provider or Contracting Provider's interest. Contracting Provider agrees to opt-out of any class action or class arbitration filed against Plan that raises claims covered by the Provider agreement to arbitrate, including, but not limited to class arbitrations that are currently pending.

C. Subject to the provisions of the Manual, Contracting Provider may elect to subject certain disputes regarding claim payment to a Billing Dispute External Review Process as described therein. The resulting determination with respect to payment of any claims that are the subject of disputes so submitted shall be binding on the parties and not be subject to other provisions contained in the Provider contract for dispute resolution.

D. Subject to the provisions of the Manual, Contracting Provider may, if Contracting Provider is acting on behalf of a Covered Person, elect to subject certain disputes concerning a determination by Plan that a service is not or will not be a Covered Service because it is not medically necessary or is experimental or investigational in nature ("Adverse Determination") to an External Review process described in the Manual. The resulting determination with respect to the appropriateness of such Adverse Determination shall be binding on the parties and not be subject to the other provisions contained in the Provider Manual for dispute resolution.

E. With respect to any arbitration provided for in the Provider Agreement, Plan shall refund any applicable filing fees and arbitrators' fee paid by Contracting Provider in the event that Contracting Provider is the prevailing party; provided, however, that this refund of filing fees and arbitrators' fees shall not apply with respect to any arbitration proceeding in which Contracting Provider purports to represent any health care providers outside of Contracting Provider. Mediation or arbitration provided for in the Provider Agreement will be held within a fifty (50) mile radius from the Contracting Provider's principal office, unless Plan and Contracting Provider mutually agree to an alternate location.

New Account Groups

All of the accounts listed below have Blue Cross and Blue Shield Coverage, unless otherwise indicated.

Group Name:	**Housing Benefits Plan**
Group Number:	**P96899, P97380, P97383-84**
Alpha Prefix:	**UHB**
Product Type:	**PPO (Portable)**
Effective Date:	**Jan. 1, 2010**

Group Name:	**The Timken Company**
Group Number:	**0744496**
Alpha Prefix:	**TPK**
Product Type:	**PPO (Portable)**
Effective Date:	**Nov. 1, 2009**

NOTE: Some of the accounts listed above may be new additions to BCBSIL, some accounts may already be established, but may be adding member groups or products. The information noted above is current as of the date of publication; however, BCBSIL reserves the right to amend this information at any time without notice. The fact that a group is included on this list is not a guarantee of payment or that any individuals employed by any of the listed groups, or their dependents, will be eligible for benefits. Benefit coverage is subject to the terms and conditions set forth in the member's certificate of coverage.

Thank you!

If you are one of the growing number of BCBSIL providers who have signed up for Electronic Funds Transfer (EFT), Electronic Remittance Advice (ERA) and Electronic Payment Summary (EPS), thank you for utilizing these electronic transactions! If your office has not yet enrolled for EFT, ERA and EPS, we encourage you to explore these time and money saving options.

Whether you're a current user or considering enrollment, we have a variety of online resources available to help you feel confident and informed. Visit the EFT/ERA page in the Electronic Commerce section of our Web site at ***www.bcbsil.com/provider/ec/eft.htm*** where you will find our EFT and ERA enrollment forms, an Electronic Options Tutorial, answers to Frequently Asked Questions (FAQs), and more.

Blue Review is a monthly newsletter published for Institutional and Professional Providers contracting with Blue Cross and Blue Shield of Illinois. We encourage you to share the content of this newsletter with your staff. *Blue Review* is located on our Web site at *www.bcbsil.com/provider*.

The editors and staff of *Blue Review* welcome letters to the editor. Address letters to:

BLUE REVIEW
Blue Cross and Blue Shield of Illinois
300 E. Randolph Street – 25th Floor
Chicago, Illinois 60601-5099
E-mail: *bluereview@bcbsil.com*
Web site: *www.bcbsil.com/provider.*

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